epic
Study of Nutrition and Health

Please see our newsletter inside

We guarantee that all information will be treated with absolute confidentiality and will be used only for medical research. To help us read your answers, please write as clearly as possible with a black pen and complete the questionnaire by putting a cross in the appropriate box(es) +

e.g. Yes [X] No [ ]

OR putting numbers in the appropriate box(es)

e.g. [0 7] [1 9 8 9]

We would like you to answer every question. If you are uncertain please do the best you can.

If your name and/or your address has changed or is incorrect, please give the correct details below:

Surname: Forename(s):

Address:

Postcode:

PLEASE COMPLETE USING A BLACK PEN

What is your date of birth? D D / M M / 1 9 Y Y

What is today's date? D D / M M / 2 0 Y Y

QUESTIONS ABOUT YOUR DIET

1. Do you eat any meat? Yes [ ] No [ ]
(including bacon, poultry, game, meat pies, sausages)

If yes, how many times a week do you eat meat? [ ] *times a week*
(remember bacon for breakfast and meat in sandwiches)

If no, how old were you when you last ate meat? [ ] *years old*

2. Do you eat any fish? Yes [ ] No [ ]

If yes, how many times a month do you eat the following?
put '0' if eaten less than once a month

Fatty fish *(e.g. sardines, salmon, mackerel, herring)* [ ] *times a month*

Other fish *(e.g. cod, tuna, haddock)* [ ] *times a month*

If no, how old were you when you last ate fish? [ ] *years old*

3. Do you eat any dairy products? Yes [ ] No [ ]
(including milk, cheese, butter, yoghurt)

If no, how old were you when you last ate dairy products? [ ] *years old*

4. Do you eat any eggs? Yes [ ] No [ ]
(including eggs in cakes and other baked foods)

If yes, how many eggs do you eat each week? [ ] *eggs each week*
put '0' if eaten less than once a week

If no, how old were you when you last ate eggs? [ ] *years old*

5. What type of milk do you use most often?

- Full cream [ ]
- Semi-skimmed [ ]
- Skimmed/fat free [ ]
- Soya milk fortified with calcium [ ]
- Soya milk not fortified with calcium [ ]
- Other [ ]
- None [ ]

How much milk do you drink each day, including milk with tea, coffee, cereals, etc.?

- Less than quarter of a pint (<150 ml) [ ]
- Quarter of a pint (150 ml) [ ]
- Half a pint (300 ml) [ ]
- Three quarters of a pint (450 ml) [ ]
- One pint (600 ml) [ ]
- More than one pint (>600 ml) [ ]

6. What type of spread do you use most often on bread, crispbreads, vegetables, etc. ?

- Butter [ ]
- Dairy spread *e.g. Clover* [ ]
- Low or reduced fat spread [ ]
- Olive based spread *e.g. Olivio* [ ]
- Polyunsaturated margarine *e.g. Flora* [ ]
- Hard margarine (in wrapper not tub) [ ]
- Soya margarine or other milk free margarine [ ]
- Cholesterol lowering spread *e.g. Benecol, Flora pro-activ* [ ]
- Other margarine [ ]
- None [ ]

How thickly do you spread it? +

thick [ ] medium [ ] thin [ ]

Do you add it to potatoes? Yes [ ] No [ ]

Do you add it to other vegetables? Yes [ ] No [ ]

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7. What type of fat do you use most often for cooking?

+

- Butter ☐
- Soft margarine ☐
- Hard margarine ☐
- Solid vegetable fat *e.g. White Flora* ☐
- Lard ☐
- Olive oil ☐
- Other vegetable oil ☐
- None ☐

8. Do you eat organic food?

- Never ☐
- Sometimes ☐
- Usually ☐
- Always ☐

9. How much bread, crispbread etc. do you normally eat each day?

put '0' if none

- White bread *slices a day* ☐☐
- Brown bread *slices a day* ☐☐
- Wholemeal bread *slices a day* ☐☐
- Crispbread *biscuits a day* ☐☐
- Sweet biscuits *biscuits a day* ☐☐

10. What type of breakfast cereal do you eat most often?

- Bran cereal *e.g. Branflakes* ☐
- Wholewheat cereal *e.g. Weetabix* ☐
- Porridge, hot oat cereal ☐
- Muesli, oat clusters, etc. ☐
- Other *e.g. cornflakes, Rice Krispies* ☐
- None ☐

How many bowls of breakfast cereal do you eat each week? *put '0' if none* ☐☐ *bowls a week*

11. How much of the following do you drink each day?

put '0' if none

- Tea *cups daily* ☐☐
- Herb tea *cups daily* ☐☐
- Coffee *cups daily* ☐☐
- Water *glasses daily* ☐☐
- Pure fruit juice *glasses daily* ☐☐
- Fruit drinks, squash *glasses daily* ☐☐
- "Diet" fizzy soft drinks *glasses/cans daily* ☐☐
- Fizzy soft drinks *glasses/cans daily* ☐☐

12. How many teaspoons of sugar, in total, do you add to tea, coffee, cereal, fruit etc. each day ?

put '0' if none ☐☐ *teaspoons each day*

13. At present, about how many alcoholic drinks do you have each week?

put '0' if none

+

- Beer, lager or cider ☐☐ *pints each week*
- Red wine ☐☐ *glasses each week*
- White wine ☐☐ *glasses each week*
- Sherry or fortified wine ☐☐ *glasses each week*
- Spirits - whisky, gin, brandy ☐☐ *glasses each week*

14. How often do you eat the following?

Please cross one box for each item

	Never	Seldom	Once a week	2-4 times a week	5-6 times a week	Once or more a day
Fresh fruit	☐	☐	☐	☐	☐	☐
Dried fruit (raw)	☐	☐	☐	☐	☐	☐
Stewed fruit, tinned fruit	☐	☐	☐	☐	☐	☐
Pasta, *e.g. spaghetti*	☐	☐	☐	☐	☐	☐
Rice	☐	☐	☐	☐	☐	☐
Pizza	☐	☐	☐	☐	☐	☐
Chips	☐	☐	☐	☐	☐	☐
Other potatoes	☐	☐	☐	☐	☐	☐
Peas	☐	☐	☐	☐	☐	☐
Baked beans	☐	☐	☐	☐	☐	☐
Lentils, dried beans	☐	☐	☐	☐	☐	☐
Tomatoes	☐	☐	☐	☐	☐	☐
Carrots	☐	☐	☐	☐	☐	☐
Green vegetables	☐	☐	☐	☐	☐	☐
Other cooked vegetables	☐	☐	☐	☐	☐	☐
Salad/raw vegetables	☐	☐	☐	☐	☐	☐
Tofu	☐	☐	☐	☐	☐	☐
Soya meat, burgers, TVP	☐	☐	☐	☐	☐	☐
Other veggie burgers	☐	☐	☐	☐	☐	☐
Cheese	☐	☐	☐	☐	☐	☐
Cottage cheese	☐	☐	☐	☐	☐	☐
Soya cheese	☐	☐	☐	☐	☐	☐
Yogurt, dairy desserts	☐	☐	☐	☐	☐	☐
Soya yogurt, soya desserts	☐	☐	☐	☐	☐	☐
Cream, ice cream	☐	☐	☐	☐	☐	☐
Soya cream, ice cream	☐	☐	☐	☐	☐	☐
Cakes, puddings, pies, buns, etc.	☐	☐	☐	☐	☐	☐
Chocolate, any type	☐	☐	☐	☐	☐	☐
Other sweets, *e.g. boiled sweets*	☐	☐	☐	☐	☐	☐
Crisps, Hula Hoops, etc.	☐	☐	☐	☐	☐	☐
Peanut butter, salted nuts	☐	☐	☐	☐	☐	☐
Other nuts and seeds not in muesli	☐	☐	☐	☐	☐	☐
Jam, marmalade	☐	☐	☐	☐	☐	☐
Yeast extract, *e.g. Marmite*	☐	☐	☐	☐	☐	☐

QUESTIONS ABOUT YOUR LIFESTYLE

15. Have you ever smoked cigarettes? Yes ☐ No ☐

If you have stopped smoking cigarettes, how old were you when you gave up? ☐☐ *years old*

If you smoke now, how many cigarettes, do you usually smoke each day? ☐☐ *cigarettes a day*

16. Do you smoke cigars? Yes ☐ No ☐

17. Do you smoke a pipe? Yes ☐ No ☐

18. Do you have a paid job at present?
Yes, full-time ☐ Yes, part-time ☐ No ☐

If yes, we would like to know the type and amount of physical activity involved in your work. *Please put a cross in the appropriate box*

Sedentary occupation - ☐
you spend most of your time sitting (such as in an office)

Standing occupation - ☐
you spend most of your time standing or walking, but your work does not require intense physical effort (e.g. shop assistant, hairdresser, guard)

Manual work - ☐
this involves some physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter)

Heavy manual work - ☐
this involves very vigorous physical activity including handling very heavy objects (e.g. docker, miner, bricklayer, construction worker)

19. In a typical week during the past year, how many hours did you spend per week on each of the following activities? *put '0' if none*

	In Summer	In Winter
Walking, including to work, shopping and during leisure time	*hours per week*	*hours per week*
Cycling, including cycling to work and during leisure time	*hours per week*	*hours per week*
Gardening	*hours per week*	*hours per week*
Do-it-yourself	*hours per week*	*hours per week*
Physical exercise such as keep-fit/aerobics, swimming, jogging, tennis, etc.	*hours per week*	*hours per week*
Housework, such as cleaning, washing, cooking and childcare	*hours per week*	

20. In a typical week during the past 12 months, did you practise any of these activities vigorously enough to cause sweating or a faster heartbeat?
Yes ☐ No ☐

If yes, for how many hours per week in total did you practise such vigorous activity? *hours per week*

21. What is your weight?
stones *pounds* **or** *kilograms*

22. Please indicate your marital status
Single ☐ Widowed ☐ Divorced ☐
Married or living as married ☐ Separated ☐

23. Please give your mother's place of birth *(town, county, country)*

24. Please give your father's place of birth *(town, county, country)*

QUESTIONS ABOUT YOUR HEALTH

25. *In the last six years,* have you had any broken/fractured bones? Yes ☐ No ☐ +

If yes, please give details (most recent first)

Month / Year	Bone(s), *e.g. hip, ankle, spine, wrist, finger*	Cause, *e.g. fall, found on X-ray, car accident*
MM / YEAR		
MM / YEAR		

26. *In the last six years,* has your doctor told you that you had any of the following?
Please complete all appropriate boxes

	Yes	Year first diagnosed	No
Cancer	☐	YEAR	☐
type of cancer:			
Polyps in large intestine	☐	YEAR	☐
Enlarged prostate (men only)	☐	YEAR	☐
High blood pressure	☐	YEAR	☐
High blood cholesterol	☐	YEAR	☐
Angina	☐	YEAR	☐
Stroke	☐	YEAR	☐
Heart attack	☐	YEAR	☐
Cardiac arrhythmias/palpitations/ irregular heartbeat	☐	YEAR	☐
Blood clot in leg	☐	YEAR	☐
Blood clot in lung or elsewhere	☐	YEAR	☐
Diabetes	☐	YEAR	☐
Thyroid disease	☐	YEAR	☐
Cataract in eye	☐	YEAR	☐
Stomach ulcer	☐	YEAR	☐
Duodenal ulcer	☐	YEAR	☐
Gallstones	☐	YEAR	☐
Have you had your gall bladder removed?	☐	YEAR	☐
Diverticular disease	☐	YEAR	☐
Crohn's disease	☐	YEAR	☐
Ulcerative colitis	☐	YEAR	☐
Asthma	☐	YEAR	☐
Bronchitis/emphysema	☐	YEAR	☐
Rheumatoid arthritis	☐	YEAR	☐
Osteoarthritis +	☐	YEAR	☐
Depression requiring treatment	☐	YEAR	☐

Other significant illnesses or operations, excluding hysterectomy - see Q.38. *Please give details, including year first diagnosed.*

27. Do you regularly take any vitamins, minerals or other supplements? Yes ☐ No ☐

If yes, do you take: *(you can cross more than one box)*

multivitamins (with minerals) ☐		vitamin A ☐	
+ multivitamins (without minerals) ☐		vitamin B (including B_6 & B_{12}) ☐	
fish oil (including cod liver oil) ☐		vitamin C ☐	
evening primrose oil ☐	garlic ☐	vitamin D ☐	
iron ☐	zinc ☐	calcium ☐	vitamin E ☐

Other *(name and brand)*

28. Have you taken any medications for most of the last 4 weeks? Yes ☐ No ☐

If yes, was it: *(you can cross more than one box)*

amlodipine *(Istin)* ☐	digoxin ☐	prednisolone ☐
amitriptyline *(Tryptizol, etc.)* ☐	HRT ☐	propranolol ☐
aspirin ☐	ibuprofen ☐	sleeping pills ☐
atenolol ☐	insulin ☐	tamoxifen ☐
bendrofluazide ☐	lithium ☐	thyroxine ☐
contraceptive pill ☐	Losec/Zoton ☐	warfarin ☐
co-proxamol *(Distalgesic)* ☐	paracetamol ☐	

Other *(name and brand)*

29. About how many bowel movements do you have each week? ☐☐ *a week*

How often do you take laxatives? *put '0' if never* ☐☐ *times a month*

30. How would you describe your health now?

excellent ☐ good ☐ fair ☐ poor ☐

QUESTION FOR MEN ONLY

31. Have you had a vasectomy? Yes ☐ No ☐

If yes, at what age? ☐☐ *years old*

QUESTIONS FOR WOMEN ONLY

32. Have you had your menopause (stopped having periods)?

Yes ☐ No ☐ Not sure *(because taking HRT, irregular periods, etc.)* ☐

+ **If yes,** how old were you when you stopped having periods? ☐☐ *years old*

33. How many periods have you had in the last 12 months? *put '0' if none* ☐☐ *periods*

34. Have you ever taken the contraceptive pill? Yes ☐ No ☐

If yes, for how long altogether have you used the pill? ☐☐ *years*
put '0' if less than one year

Are you currently taking the contraceptive pill? Yes ☐ No ☐

If no, at what age did you stop? ☐☐ *years old*

35. Have you ever taken Hormone Replacement Therapy (HRT)? Yes ☐ No ☐

If yes, for how long altogether have you used HRT? ☐☐ *years*
put '0' if less than one year

Are you currently taking HRT? Yes ☐ No ☐

If no, at what age did you stop? ☐☐ *years old*

36. *During the last six years,* have you had any children? Yes ☐ No ☐

If yes, please enter the year(s) of birth and sex below:

1. Y E A R Boy ☐ Girl ☐
2. Y E A R Boy ☐ Girl ☐
3. Y E A R Boy ☐ Girl ☐

37. Have you ever had a son born with either of the following conditions?

	Yes	Year of birth	No
Hypospadias (hole for urinating in the wrong place)	☐	Y E A R	☐
Undescended testicles (Cryptorchidism)	☐	Y E A R	☐

38. Have you had a hysterectomy (womb removed)? Yes ☐ No ☐

If yes, at what age? ☐☐ *years old*

39. Have you had an operation to remove one or both ovaries? Yes ☐ No ☐ Don't know ☐

If yes, were one or both ovaries removed?

One ☐ Both ☐ Don't know ☐

At what age? ☐☐ *years old*

40. Have you ever had breast screening by mammography (x-ray)? Yes ☐ No ☐

If yes, how many times in the last ten years? ☐☐

When did you last have a breast screen? *please enter year* Y E A R

41. Have you ever had a cervical smear test? Yes ☐ No ☐

If yes, how many times in the last ten years? ☐☐

When did you last have a cervical smear? *please enter year* Y E A R

THANK YOU VERY MUCH FOR YOUR HELP Please return this questionnaire in the pre-paid envelope

PLEASE RETURN TO: DR T KEY, EPIC STUDY, UNIVERSITY OF OXFORD, GIBSON BUILDING, RADCLIFFE INFIRMARY, WOODSTOCK ROAD, OXFORD OX2 6HE
IF YOU HAVE ANY QUESTIONS PLEASE TELEPHONE 01865 - 516329